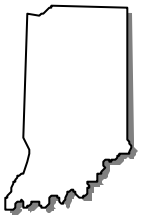
Indiana Health Coverage Programs



**P R O V I D E R  B U L L E T I N**

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## To: All Providers

## Subject: Mandatory MCO Enrollment Update

## Overview

*Bulletin BT200140 Revised – Mandatory MCO Enrollment*, dated October 30, 2001, and *Bulletin BT200209 – Mandatory MCO Enrollment Update*, dated February 22, 2002, outlined the State's plan to implement mandatory enrollment in a managed care organization (MCO) in seven, highly populated counties: Allen, Elkhart, Hamilton, Lake, Marion, St. Joseph, and Vanderburgh. Allen and Marion Counties were successfully transitioned April 1, 2002; Elkhart and St. Joseph Counties are scheduled for July 1, 2002, and Lake County is scheduled for October 1, 2002. This bulletin further explains the implementation of mandatory member enrollment in an MCO for these counties in 2002, and the potential impact on Indiana Health Coverage Programs (IHCP) providers.

## Mandatory MCO Enrollment Update

As stated in *Bulletin BT200209*, the Centers for Medicare and Medicaid Services (CMS) approved mandatory MCO enrollment for three of the seven counties – Allen, Marion and Lake. CMS approval for Elkhart, St. Joseph, Hamilton, and Vanderburgh Counties was pending based on additional information. **In May 2002, the State received approval for mandatory MCO enrollment for Elkhart and St. Joseph Counties, so the July 1, 2002, transition will take place as scheduled.** Mandatory MCO enrollment in Hamilton and Vanderburgh Counties did not receive approval at this time. Therefore, the October 1, 2002, mandatory MCO transition will only include Lake County.

As a reminder, providers who render services to Hoosier Healthwise members in the affected counties should review the following to determine the impact of the upcoming changes:

- Mandatory MCO enrollment does not apply to IHCP members who are designated by an aid category of Aged, Blind, or Disabled. These members continue their traditional Medicaid/IHCP coverage. For an IHCP member to qualify as for the Disabled aid category, **the member must initiate** a disability determination request by contacting his or her caseworker at the local Department of Family and Children (DFC) office. The request for Medicaid disability determination must come from the member and cannot be made by a health care provider or other third party.
- Primary Medical Providers (PMPs) in the affected counties can choose to contract with one of the Hoosier Healthwise MCOs or disenroll as a Hoosier Healthwise PMP. PrimeStep PMPs who contract with one of the MCOs with an effective date of July 1, 2002, for Elkhart and St. Joseph Counties and October 1, 2002, for Lake County will retain their current Hoosier Healthwise members. Disenrolling PMPs can choose to remain as IHCP providers, but will be limited to non-Hoosier Healthwise members.
- MCOs can provide additional services to members that complement services provided by the PMPs. Examples include 24-hour nurse telephone services, enhanced transportation arrangements, and case management services.
- MCOs have various network arrangements with specialists, PMPs, hospitals, and ancillary providers. Some of the networks are currently *open*, meaning that any IHCP provider can render services to the MCO members, although prior authorization (PA) may be required. MCOs must pay out-of-network (non-contracted) providers 100 percent of the Medicaid rate, unless they have an agreement with the provider. However, some networks are *closed* such as transportation and pharmacy networks. With *closed* networks, MCO-contracted providers usually render the services.
- Mandatory MCO changes **will not** affect providers rendering care to MCO members for carved-out services. Claims for those services continue to be processed by EDS. Claims related to carved-out services, however, are the responsibility of the MCO. An upcoming bulletin will have more information about this topic.
- Mandatory MCO changes do affect the self-referral providers, such as podiatrists, vision care, and chiropractors. MCOs are responsible for payment of the self-referral services for their members. Claims for these services must be sent to the appropriate MCO for payment.

Additional information about mandatory member transition can be found at the IHCP Web site at http://www.indianamedicaid.com.

A federally qualified health center (FQHC) can participate with a capitated MCO. MCO provider contracts must specify the contractual arrangements to ensure that FQHCs and rural health centers (RHCs) are reimbursed for services. The OMPP endorses the following types of contractual arrangement:

- The FQHC or RHC accepts full capitation for primary, specialty, or hospital capitation from the MCO.
- The FQHC or RHC accepts a partial capitation or other method of payment at less than full risk for patient care, such as primary care capitation only, or fee-for-service.

Please refer to *Bulletin BT200140 Revised – Mandatory MCO Enrollment* dated October 30, 2001, and *Bulletin BT200209 – Mandatory MCO Enrollment Update* dated February 22, 2002, for additional information about mandatory MCO enrollment in selected Indiana counties. Table 1.1 lists active MCOs in Indiana, the active regions in the State, and the telephone numbers.

## Managed Care Organizations

Table 1.1 – Managed Care Organizations

| Organization | Region | Transition counties | Provider Service Phone Number |
|---|---|---|---|
| Harmony Health Plan | North | Allen, Elkhart, Lake, and St. Joseph | 1-800-504-2766 |
| Managed Health Services (MHS) | Statewide | All transition counties | 1-800-414-9475 |
| MDwise | Central* | Marion | 1-800-356-1204 or (317) 630-2831 |

* MDwise is currently expanding into additional areas of the State of Indiana.

## Additional Information

Additional information, including MCO network summaries, is available from the IHCP Web site at http://www.indianamedicaid.com. Questions about the information in this bulletin should be directed to the appropriate MCO listed in Table 1.1 above, or Lifemark at 1-800-889-9949, Option 3.